



Written Submission to the Northern Ireland Audit Office

Review of Prescribing in Northern Ireland

Submitted by New Script for Mental Health

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Introduction

New Script for Mental Health welcomes the Northern Ireland Audit Office's review of prescribing in Northern Ireland.

[New Script for Mental Health](#) is a grassroots, rights-based movement in Northern Ireland working to change how mental health and distress are understood and responded to. Drawing on lived experience, it challenges approaches that focus primarily on diagnosis and medication and promotes a more contextualised, trauma-informed, and non-medicalised understanding of mental health.

New Script campaigns for greater recognition of the social, economic, and systemic issues that shape people's wellbeing, accountability across mental health services, a wider range of healing options beyond medication, and voice, choice and agency for people using services.

Our work includes campaigning for a reduction in the overprescribing of antidepressants, promoting the [Give 5: Steps to a Wellbeing Rights Framework](#), and using research, advocacy, public education, and community organising to build a different narrative around mental health.

We recognise that medicines are an important and essential part of healthcare, and that appropriate prescribing makes a significant contribution to people's health and wellbeing. Our concern is not with medication itself, but with whether the current system is sufficiently focused on appropriate prescribing, informed choice, meaningful alternatives, patient experience, and the wider factors that influence prescribing decisions.

We believe that our work on addressing the unnecessary overprescribing of antidepressants provides an important case study of wider issues within primary-care prescribing: increasing rates of prescribing; significant inequalities in prescribing; the availability or otherwise of non-medical alternatives; informed consent; withdrawal; the influence of social and economic circumstances on prescribing; and whether existing approaches to medicines optimisation are sufficiently broad.

Our submission draws on work New Script for Mental Health has undertaken over a number of years, bringing together lived experience with analysis of official prescribing data, Freedom of Information analysis, research, and policy analysis.

The analysis and recommendations that follow relate specifically to antidepressant prescribing. While we believe that many of the issues identified may have wider applicability across primary-care prescribing, we do not seek to generalise the findings beyond the evidence relating to antidepressants.

1. Prescribing must be considered in the context of why medicines are being prescribed.

The Audit Office notes that it will examine how prescribing in primary care has changed since 2014. Our analysis of antidepressant prescribing suggests that these changes cannot be understood simply in terms of cost, volume, or efficiency.

In 2019, 3.4 million antidepressant prescriptions were issued by GPs in Northern Ireland, at a cost of £11.4 million. This represented a [5.2% increase in prescriptions in a single year](#). At the time, we highlighted the lack of adequate attention to the relationship between rising antidepressant prescribing and the availability of accessible alternatives such as counselling and talking therapies.

New Script analysis of more recent [official figures](#) shows that the rise in prescribing rates has continued. In 2025/26, 21% of the population received at least one antidepressant prescription, an increase of 1.8% in one year. Four in ten women aged 45–64 received an antidepressant during the year, while people living in the most deprived communities were more than one-and-a-half times as likely to receive antidepressants as those in the least deprived communities.

These figures raise a fundamental question for any review of antidepressant prescribing: what is driving the continued increase, and how do clinical need, prescribing practice and the social and economic conditions in which people are living interact?

New Script has consistently argued that distress cannot be separated from poverty, inequality, trauma, discrimination, isolation, racism, violence, housing insecurity, and lack of power. The concentration of prescribing among populations experiencing the greatest levels of deprivation should prompt examination of the wider context in which prescribing takes place. This is not an argument against antidepressants. Rather, it is an argument for asking whether the health system is sometimes using a medical intervention to respond to problems that also require social, economic and community responses.

[The NIAO's 2014 review of primary care prescribing](#) provides important context. It identified rising antidepressant prescribing, significant variation in prescribing and the need to understand the relationship between prescribing and health need, while recognising that factors such as access to other services can influence prescribing behaviour. It recommended that significant variations in prescribing should be investigated. However, its analysis of antidepressants focused principally on the efficiency and cost of the medicines prescribed, including opportunities to substitute lower-cost alternatives.

More than a decade later, New Script believes the current review provides an opportunity to examine these issues more broadly: not simply whether medicines are being prescribed cost-effectively, but why antidepressant prescribing continues to rise, what influences prescribing decisions, whether people have meaningful access to alternatives, and whether medicines optimisation is delivering the outcomes people need.

[The 2023 report Our Lives, Our Meds, Our Health: Exploring Medication Safety Through a Social Lens](#), produced by the Community Development & Health Network in collaboration with Queen's University Belfast, provides further context for considering prescribing costs and value for money. Its findings demonstrate that medication use and medication-related

harm are shaped not only by clinical factors, but also by poverty, social and economic conditions, health literacy, stigma, access to services and people's ability to manage complex medication regimes. The report therefore highlights the importance of looking beyond prescribing volume and financial cost to consider whether medicines are appropriate, effective, and beneficial for the people receiving them, and whether avoidable medication-related harm or waste is occurring.

There is, however, a significant gap in the information currently available to understand these prescribing patterns. The Department of Health has indicated that [no research is planned](#) into the reasons for the rise in antidepressant prescribing because this would require information on the reason for prescribing. It has also stated that dispensing data cannot establish the medical condition for which an individual antidepressant has been prescribed, as antidepressants are used to treat a range of conditions.

We recognise that dispensing data alone cannot establish clinical indication. However, we do not consider this limitation a sufficient reason not to investigate the continuing rise in prescribing. The Department's existing data already demonstrate substantial variation by sex, age, deprivation, and geography. These patterns do not, in themselves, demonstrate inappropriate prescribing, but they raise important questions about the factors contributing to prescribing and whether people are receiving the most appropriate combination of medical, psychological, social, and community-based support.

The marked gender difference provides a clear example. In response to a question about why 26% of women compared with 16% of men received an antidepressant in 2025/26, the [Department again pointed to the absence of indication data](#). The issue is not to assume that this difference represents inappropriate prescribing, but to ask why it exists and whether differences in clinical need, access to alternative support, prescribing practice or wider social circumstances contribute to the pattern. A substantial and recurring gender difference is being identified, but the factors contributing to it are not being investigated.

The absence of indication data should therefore be treated as a research and data gap to be addressed. Research need not rely solely on dispensing data. It could involve linking prescribing data, where appropriate and subject to the necessary safeguards, with GP clinical records and information on diagnoses, duration and repeat prescribing, medication reviews, and access to other forms of support. It could also include qualitative research with prescribers and people receiving antidepressants to understand the factors influencing prescribing decisions and patient choice.

Scotland provides a useful example of how the absence of clinical-level prescribing information need not be a barrier to investigating rising antidepressant use. The Scottish Government's 2014 [Key Information on the Use of Antidepressants in Scotland](#) acknowledged that routine prescribing data could not identify the condition for which an antidepressant had been prescribed but nevertheless identified the need for further research using clinical and research databases. Its current [Quality Prescribing for Antidepressants: Guide for Improvement 2024–2027](#) goes further, recommending that the indication for antidepressant treatment is recorded in clinical records, alongside proactive medication reviews, and consideration of non-pharmacological and psychological interventions.

There is therefore a clear lesson for Northern Ireland: where available data does not provide the information needed to understand a significant and continuing prescribing trend, this

should be treated as a gap to be addressed through research, data linkage and improved data collection—not as a reason for no further investigation.

2. Medicines optimisation must mean more than achieving financial savings

We note that reducing costs and improving efficiency are key elements of the review's remit. However, in our view, medicines optimisation needs to be understood more broadly, and should also ask:

- Is the medicine clinically appropriate?
- Has the person been given sufficient information about benefits and risks?
- Have alternatives been discussed?
- Does the person understand what they are consenting to?
- Are regular reviews of medication being conducted?
- Is there adequate support to reduce or discontinue the medicine where appropriate?
- Are withdrawal effects properly recognised?
- Are people's experiences of medicines being systematically captured?
- Are prescribing patterns being examined in relation to deprivation, gender, age, and geography?
- Are resources being allocated in a way that gives people meaningful choices?

New Script's view is that 'medicines optimisation' should mean more than reducing prescribing costs or improving technical efficiency. It should ensure that medicines are appropriate, effective, and safe; that people are involved in decisions about their treatment; that medicines are regularly reviewed; and that appropriate alternatives and support are available where medication is not the only or most appropriate response.

In relation to discussing and offering alternatives, there is evidence that limited access to non-medical options can make antidepressant prescribing the most readily available response for both GPs and patients. For example, the antidepressant budget across the five Health and Social Care Trusts was just under £13 million in 2023, while [spending on talking therapies was under £3 million](#). New Script FOI investigations found that in 2019/20, [four of the five Trusts had handed back money ring-fenced for talking therapies](#), while only around two-thirds of GP practices offered in-house counselling. The important issue is not simply the difference between budgets or between provision across different Trusts. It is whether the health system has created a sufficiently balanced range of options for people experiencing distress. If medication is substantially easier to access than non-medical support, prescribing decisions may inevitably be influenced by the options available to clinicians and patients.

[Wider research involving GPs](#) found that 66% had prescribed an antidepressant despite believing an alternative treatment might have been more appropriate because a suitable alternative was unavailable, while 62% had done so because of a waiting list for that alternative; 60% said they would prescribe antidepressants less frequently if other options were available.

The Royal College of General Practitioners has also acknowledged the difficulty of providing the time required for mental-health consultations within standard 10-minute appointments, [alongside patchy and slow access to talking therapies](#). Taken together, this suggests that prescribing patterns cannot necessarily be understood solely in terms of individual clinical

decisions; they also need to be considered in the context of consultation time, service capacity, and the availability of realistic alternatives.

Finally, the Department of Health has previously acknowledged the link between reducing antidepressant prescribing and investing in alternatives. [In evidence to the Assembly](#), a Departmental official described how prescribing efficiencies had generated real cash savings, including £1.4 million reinvested in Belfast into primary-care talking therapies and primary-care hubs. The official explained that reducing expenditure on antidepressants was being used to create funding that could then be reinvested in counselling and psychological therapies. This provides further evidence that medicines optimisation cannot be considered in isolation from the availability of alternatives: reducing prescribing without reinvesting in accessible non-medical supports risks simply reducing one form of provision without creating meaningful choice for patients. This relationship should form part of any assessment of medicines optimisation and value for money.

Yet, as recently as July 2026, in [response to an Assembly question](#), the Department confirmed that no assessment has been undertaken of the relationship between antidepressant prescribing rates and the availability of talking therapies. While acknowledging the value of non-pharmaceutical supports, including talking therapies, the Department has not examined whether access to such alternatives is related to increasing antidepressant prescribing.

A 2024 report from the influential parliamentary All-Party Group *Beyond Pills*, '[Shifting the Balance Towards Social Interventions](#)', provides a relevant wider evidence base for the urgent need to shift the balance towards social intervention, as per its report title. It identifies concerns about over-reliance on biomedical approaches and calls for greater investment in social prescribing, community-based support, and psychosocial interventions, alongside action to reduce unnecessary antidepressant prescribing, strengthen informed consent and improve support for withdrawal. These recommendations reinforce New Script's view that medicines optimisation should be considered in the context of the alternatives available to people and the wider social circumstances in which prescribing takes place. The report therefore supports a broader approach to assessing value for money—one that considers not only prescribing costs and volumes, but also appropriateness, patient experience, outcomes, safe discontinuation and whether people have meaningful access to non-medical responses to distress.

3. Informed consent and the long-term consequences of prescribing

Our work has identified significant concerns about the information people receive about antidepressants, particularly in relation to potential side-effects and withdrawal. There has been widespread, growing global concern around the potential harms caused by antidepressants, and the lack of adequate information being provided by prescribers. [Groups](#) led by people who have experienced medication-induced harm, [alongside families](#) who have lost loved ones to antidepressant-induced suicide, are campaigning for safer prescribing, better recognition of adverse reaction and greater awareness of antidepressant-induced suicide and withdrawal harms.

In 2023 we [highlighted evidence](#) from a BBC Panorama investigation that people taking antidepressants may not be adequately informed about withdrawal effects. Updated guidance from [NICE](#) and the [Royal College of Psychiatrists](#) recognises that antidepressant withdrawal can sometimes be severe and may require gradual dose reduction over months or longer for

some people. This reinforces the importance of discussing potential withdrawal and the possible duration and difficulty of discontinuation when treatment is initiated, rather than only when someone subsequently seeks to stop.

[A 2026 research paper by Dr. Anne Guy et al](#) examined patient experiences of antidepressant withdrawal and found evidence of people experiencing severe symptoms after reducing or stopping medication, with many reporting that their symptoms were interpreted as relapse rather than withdrawal. The analysis identified concerns around informed consent, recognition of withdrawal and the adequacy of tapering advice.

4. Patient experience should be treated as evidence

Our work on antidepressant withdrawal also highlights the importance of incorporating patient experience into assessments of prescribing. In the [2026 study cited above](#), patients described being dismissed or misdiagnosed when experiencing withdrawal symptoms. In some cases, withdrawal symptoms were interpreted as relapse or as evidence of a different medical condition. If withdrawal is incorrectly interpreted as relapse, a person may be prescribed additional medication or remain on medication unnecessarily.

Recent developments in England, where [patient and family experiences have informed a review of antidepressant safety information](#) by the Commission on Human Medicines (CHM), underline the importance of listening to people with lived experience and ensuring that information about medicines reflects people's real-world experiences. The review was launched after concerns were raised by families and patients that current safety warnings in the Patient Information Leaflets (PIL) for these medicines did not clearly explain certain side effects – specifically suicidal behaviours and sexual dysfunction that may continue after treatment is stopped. Based on the group's recommendations, the CMH has advised that the wording on the PILs provided with antidepressant medication should be strengthened to provide greater clarity on the risk of suicidal behaviour.

Patient experience should therefore be treated as an important source of evidence alongside clinical, prescribing, and other forms of evidence. We believe the Audit Office should consider whether patient experience is adequately incorporated into existing medicines optimisation programmes and prescribing reviews.

5. A different approach: Give 5

New Script has developed the [Give 5: Steps to a Wellbeing Rights Framework](#) as a practical way of thinking differently about mental health and wellbeing, including the most appropriate and effective ways to respond to emotional distress and trauma at an individual level, as well as at the deeper structural level. This framework has been endorsed by all six main political parties in Stormont.

Give 5 sets out five interconnected elements as follows:

1. Connect – the symptoms of distress to their root causes.
2. Be Active – in challenging the overprescription of drugs and in providing community-based options for healing.
3. Take Notice- of people's positive healing experiences and act on their knowledge and experience.

4. Keep Learning- from the failures of previous policy and practice.
5. Give People the dignity, compassion, and hope to which they are entitled.

The framework recognises that wellbeing is shaped by relationships, belonging, meaningful activity, purpose, respect and having a voice. It calls for greater investment in community-based supports and a wider range of responses to distress beyond a predominantly medical model. It sets out what a wider system supporting appropriate prescribing could look like in practice.

Connect asks whether the system understands and responds to the social and structural circumstances contributing to distress, rather than treating symptoms in isolation. Be Active asks whether people have access to a meaningful range of options, rather than medication becoming the most readily available response. Take Notice places lived experience at the centre of understanding what works, including people's experiences of medication, withdrawal, alternatives, and recovery. Keep Learning reinforces the need to investigate persistent prescribing trends, inequalities, and unexplained variations, and to learn from previous policy and practice. Give People Dignity places choice, informed consent, compassion, and respect at the heart of care.

In this sense, Give 5 is relevant not because it prescribes a particular alternative to medication, but because it provides a framework against which the wider system supporting prescribing can be considered. It raises questions about whether people have genuine choice, whether investment is sufficiently balanced between medication and other forms of support, whether lived experience informs decision-making, and whether the health system is addressing the conditions that contribute to distress. These are all relevant to assessing whether medicines optimisation is delivering genuine value for money and better outcomes for people, rather than simply reducing prescribing expenditure.

6. Our recommendations

Based on the evidence and analysis set out above, we recommend that the Audit Office consider the following:

1. Examine why prescribing is increasing

The review should examine the factors driving increases in prescribing since 2014, including clinical need, prescribing practice, social and economic conditions, and access to alternative forms of support.

2. Assess medicines optimisation against outcomes, not only savings

Medicines optimisation should be assessed against appropriate and effective use, patient safety, informed consent, patient experience, outcomes, inequalities, access to alternatives and meaningful choice, as well as financial savings.

3. Examine prescribing alongside access to alternatives

The Audit Office should examine whether the availability and accessibility of talking therapies and other non-medical interventions influence prescribing decisions, including differences between Trusts and geographical areas.

4. Strengthen informed consent

Patients should receive clear, balanced information about the potential benefits, risks, side effects, alternatives, and withdrawal effects of medicines, enabling meaningful and informed choice.

5. Include the whole prescribing journey

Medicines optimisation should encompass initiation, informed consent, ongoing review, monitoring, adverse effects, duration of treatment and safe discontinuation—not simply the decision to prescribe.

6. Improve recognition of withdrawal

Systems should ensure that clinicians have practical, evidence-based guidance to recognise and distinguish withdrawal from relapse and to support people who want to reduce or stop medication.

7. Use prescribing data to identify and investigate inequalities

Prescribing data should routinely be examined according to deprivation, gender, age, and geography, with substantial and persistent differences investigated rather than simply reported.

8. Put lived experience at the centre

Patient and family experience should be systematically incorporated into medicines optimisation, prescribing policy and assessments of whether medicines are achieving outcomes that are safe and effective.

9. Address gaps in the evidence base

Where existing prescribing data cannot explain significant or persistent prescribing patterns, this should be treated as a research and data gap to be addressed through improved data collection, linkage, and qualitative research.

10. Invest in alternatives

Efforts to reduce inappropriate or unnecessary prescribing should be accompanied by investment in accessible community-based, psychological, and other non-medical responses to distress, so that people have meaningful choices.